

Hiram Young, of this place, supposed to be threatened with abortion. She stated that the waters had escaped; there was slight hemorrhage and strong uterine pains. I kept her in a recumbent position, and gave a mild cathartic. In five or six days she was able to walk about the house, and soon recovered her usual health. On the 21st day of May following, I delivered her of a healthy child. In tracking the cord for the placenta, I came in contact with a dead fetus of five months.

INDEPENDENCE, Mo., Jan. 1, 1855.

DOMESTIC SUMMARY.

Peritonitis in Typhoid Fever, without Intestinal Perforation.—The following very interesting case was read to the College of Physicians of Philadelphia, by Prof. G. B. Wood.

"J. B., aged seventeen years, entered the Pennsylvania Hospital on the 2d of January. According to his own account, he had been three days ill; but the symptoms, which were those of typhoid fever in the middle of its course, evinced that he was in the second week of the disease. The tongue was quite dry, and the abdomen tympanitic; and the characteristic red spots, if not present at the time of his entrance, made their appearance very soon afterwards. Under the plan of treatment usually pursued in the hospital, including the use of oil of turpentine as an alternative to the ulcerated surfaces in the intestinal mucous membrane, he gradually amended; and, on the 20th, I presented him to the class in attendance upon the clinical lectures as quite convalescent. On the 21st, however, he was suddenly seized with severe abdominal pains, tenderness on pressure, and great prostration; and it was evident that he was labouring under an attack of violent peritonitis. I had no doubt of the existence of perforation of the bowel, which I felt disposed to ascribe to an orange which he had surreptitiously eaten a few days previously, and of which, in order to conceal his violation of the rules of the ward, he had probably swallowed the seeds and rind. With this conviction of the nature of the case, I directed the use of sulphate of morphia largely, according to the well-known plan of Drs. Graves and Stokes, with perfect rest, a blister over the abdomen, and, towards the close of the case, stimulants in order to support life. The system never fully reacted, and death took place on the 25th.

"Dr. Forbes, one of the resident physicians of the hospital, opened the body, and found a small quantity of turbid liquid in the abdominal cavity, with evidences of almost universal inflammation of the peritoneum; but, on the closest and most careful inspection, could discover no perforation of the bowel; nor was there the slightest fecal odor in the liquid effused. I had afterwards an opportunity of examining the whole of the intestines, though not *in situ*. The internal surface of the ileum presented several recent and well-defined cicatrices, finely marking the boundary of the patches of Peyer's glands, which I exhibited to the class as the finest example I had seen of this appearance; but there was not a single remaining ulcer visible, and I could find no sign of an opening. The peritoneal coating was covered with a very thin, glutinous, and translucent exudation of coagulable lymph, but with little redness. At no one point upon the surface were there more decided marks of inflammation than elsewhere, to indicate the possible seat of an opening. I was compelled, therefore, to regard the case as one of peritonitis without perforation. No discoverable cause of the affection existed; and I am inclined to rank this with those not very uncommon cases, in which peritonitis comes on without any special known cause, at the close of long-continued and exhausting affections, perhaps in consequence of depravation of the blood.

"This case is calculated to throw great doubt upon the existence of intestinal perforation in those instances of peritonitis, occurring in the advanced

stage of typhoid fever, in which cures have been effected, of which I have been so fortunate as to witness two, in my own experience. They may have been, as in the case just related, nothing more than simple peritonitis without any opening whatever through the coats of the bowel. One important practical inference, however, may be deduced from them, viz: that the opiate treatment is the one best adapted to peritonitis occurring under these circumstances, whether with or without perforation; as several instances of recovery have taken place under that treatment, while I am not aware that one is on record effected under any other plan."—*Summary of Transactions Coll. Phys. Phil.*, Vol. II., N. S., No. VII.

A Grain of Coffee in the Air-Passages—fatal after being retained nearly three years and a half.—At the Meeting of the College of Physicians of Philadelphia, Nov. 1, 1854, Dr. Wm. Pepper related the following interesting case:—

On the 22d March, 1844, a little girl, aged eighteen months, whilst playing on the floor, was suddenly seized with a violent spasmodic cough, threatening strangulation. The mother recollected that the child had been amusing itself with an uncooked grain of coffee, and immediately suspected that it had been swallowed and was the cause of all the difficulty. The room was carefully searched, but the grain could not be found; and this but confirmed the mother's conviction. Dr. Maris saw the child an hour or two after the accident; she was then in a disturbed sleep, with hurried breathing and suffused face; in a few moments she was aroused by a return of the same agonizing cough and spasm. Various expectorants were now administered, but without relief; and the remissions and exacerbations of the cough continued to recur every few minutes.

After an interval of about six hours, I was requested to see the child; but found her so much oppressed and restless, that it was almost impossible to auscult with any degree of accuracy. The respiratory murmur on the right side was exceedingly feeble, and, in a great measure, masked by loud sonorous râles, whilst on the opposite side the murmur was unusually loud; throughout the entire chest, the percussion was perfectly natural. The history of the case, confirmed by the physical signs, left but little doubt as to the nature of the accident, and tracheotomy was accordingly proposed. This, however, was rejected by the father, under the impression that the symptoms might be owing to some other cause, and in the hope that, even if our fears were well founded, the coffee-grain might be spontaneously expelled. Upon several occasions, when the violence of the cough indicated that the grain had been driven into the larynx, the child was inverted, in the hope that gravity might assist in its expulsion; but this expedient only tended to increase the alarming symptoms, and was therefore abandoned. From this time, I did not see her until the early part of August, 1847, a period of more than three years. Dr. Maris, however, informed me that, a few weeks after the accident, the paroxysms of cough gradually became less violent and of shorter duration, whilst the intervals were much longer, lasting sometimes for several weeks, during which the child was comparatively comfortable, and gained both flesh and strength, but never entirely free from difficulty of breathing. Finally, hectic fever and purulent expectoration set in, and she became greatly emaciated. Upon examination, I now found dulness on percussion over the lower part of both lungs, but particularly on the right side, and the respiratory murmur throughout was completely masked by loose mucous râles; the prostration, however, was so great as to preclude the possibility of a more extended examination. From this time she gradually sank, and finally became comatose, and died on the 24th of the month—just two weeks after my last visit, and about three years and five months from the time of the accident.

The body was examined the following day. Upon opening the thorax, care was taken to remove both lungs, with the trachea, larynx, and œsophagus adherent, without incising these parts; gentle pressure was now made with the finger along the course of the trachea, from below upwards, until the larynx was reached, when the grain of coffee was seen to escape from the chink of the glottis. It, apparently, had undergone no important change from its long

stay in the air-passages: it had not materially increased in bulk from absorption of moisture, as might have been expected, nor was it even coated with pus, mucus, or other animal matter, and its usual colour was well preserved; upon the application of considerable force, it could, however, be slightly flexed. The mucous membrane of the larynx and trachea was thickened, minutely injected, and coated throughout with tenacious muco-puriform matter; and this condition of things extended throughout the bronchial tubes, as far as examined. At the bifurcation of right bronchus, the membrane presented a worm-eaten appearance, and was much softened, though not absolutely ulcerated. The entire right lung was hepatized, and about one-half of the left lung, at its lower part, was in a similar condition. No abscess or tubercular degeneration existed in either lung, nor were there any pleuritic adhesions.

The condition of the right bronchus, at its bifurcation, renders it highly probable that the foreign body was lodged the greater part of the time at this point. The chronic inflammation of the left bronchus and lung may have been owing to an extension of the inflammation from the right side, where it undoubtedly first commenced; or it may have been induced by the occasional lodgement of the coffee-grain in the left bronchus, after having been driven into the trachea or larynx. Judging from the size of the foreign body, compared with the caliber of the bronchus at the tender age at which the accident happened, it is highly probable that the air must at the first have been almost entirely excluded from the right lung; and this must have been still more the case when lodged in the left bronchus, owing to its comparatively small size. It has been admitted by all observers, that when the foreign body is irregular in shape it is more apt to become permanently fixed in the bronchial tubes, and at the same time to interfere less with the respiratory movement, than when it is round or oblong, and thus completely plugs up the tube, as was the case in the present instance; and this fact fully explains the great fluctuations in the symptoms.—*Quarterly Summary Trans. Coll. Phys. of Phila.*, Vol. II., N. S., No. VII.

Achillaea Millefolium in Hemorrhage.—Dr. B. H. COATES stated, at the meeting of the College of Physicians of Philadelphia, on Dec. 6, 1854, that he had used an infusion of *achillaea millefolium*, with material advantage, in several cases of hemorrhage; two from the kidneys, three (in the same subject) from the uterus, and one from the lungs. The formula was half an ounce of the herb to a pint of hot water; to digest for twenty minutes. The dose of this infusion to be taken cold is half a teacupful every two hours.—*Summary of Trans. Coll. Phys. Phil.*, Vol. II., N. S., No. VII.

Erigeron Philadelphicus in Uterine Hemorrhage.—Dr. WILSON read to the Philadelphia College of Physicians, Nov. 1, 1854, notes of some cases of uterine hemorrhage successfully treated by the essential oil of *Erigeron Philadelphicus*. Dr. Wilson, whose attention was drawn to this article by Dr. A. C. Bournonville, who had used it in some few cases with advantage, states that he has prescribed it in many cases, and very generally with decided advantage. He prescribes it in doses of five drops every two hours.—*Quarterly Summary Trans. Coll. Phys. Phil.*, Vol. II., N. S., No. VII.

Ligature of the Gluteal Artery.—Dr. WARREN STONE has lately performed this operation in the Charity Hospital, on a boy, ten years of age, who had a large pulsating tumour in the gluteal region, following a wound by a narrow bladed knife, on the 28th December, 1854. The operation was performed on the 7th of February last, in the following manner: Dr. Stone made an incision across the top of the tumour, following the course of the fibres of the gluteus major muscle, eight inches in length, scooped out the coagulated blood, the sack being freely opened, and placed his finger upon the artery to control hemorrhage; a ligature was then placed around the artery, and a compress of lint gently applied to stop a slight oozing which existed from the neighbouring parts. The wound was drawn together by adhesive straps, an opiate was given,

and the patient put to bed. On the 24th February the patient was discharged, the wound being nearly healed.

Dr. Stone states that this is the third case of this lesion which has come under his care.

"The first case was brought to the Charity Hospital in 1835, considerably exhausted by the loss of blood, from a wound of this artery; it was treated by compression. The wound healed; but, about two weeks after, a small tumour was discovered in the region of the gluteal artery, which, upon auscultation, gave the usual aneurismal murmur. The tumour seemed dense, as if considerable lymph had been thrown out and organized for its protection, and pulsation was only observed when its walls were compressed. This patient remained in the Hospital about six weeks, and as the tumour did not increase, he was discharged; being warned of his condition and advised to return if the swelling should increase; but I heard no more of him. The second case was admitted into the Hospital in 1853, completely exhausted from the loss of blood. The wound was made six days previous to my visit to him, and he had suffered repeated bleedings. At the time I first saw him, he appeared perfectly bloodless, and nearly pulseless, having just had a hemorrhage, and it was thought that he could not bear the operation. Stimulants were administered, and in about an hour the pulse became steady; and as the operation offered the only possible chance for life, he was placed upon the operating table, and the artery tied. The operation was made by making an incision from near the posterior superior spine of the ischium, to the upper part of the trochanter major (which, from the distention of the parts by the coagulium beneath the muscle, was near a foot in length), the coagulium was scooped out, and the finger placed upon the artery just where it emerges from the pelvis. In the upper part of the ischiatic notch, it was found that the artery was cut very near to the finger, and it was with great difficulty that a ligature was placed upon it; this was finally done, and the patient was carefully stimulated and nourished; but, in spite of the greatest care, gangrene took place in the wound, in consequence of the great loss of blood, and he died on the fourth day after the operation.

"By most surgeons," Dr. Stone remarks, "it is considered sufficient to tie the artery on the proximal side of the wound; but Mr. Guthrie insists that it is important to tie the artery on both sides of the wound, at least when it occurs in the arteries of the extremities, as the free anastomosis, he asserts, renders hemorrhage very certain from the distal extremity. I have tied most of the large arteries for wounds, and in most cases have applied a simple ligature at a convenient place on the proximal side of the wound, and have never been troubled with hemorrhage from the distal orifice, except in one case. This was in a wound of the plantar arch, in a case that was admitted into the Hospital sixteen days after it was received. The patient, a little boy of ten years, was completely exhausted from repeated hemorrhages, and I tied the two tibial arteries, the anterior one on the dorsum of the foot, and the posterior one behind the inner malleolus. Three days after, he bled again, but not very freely, and it was thought a little pressure would command it; but the next day it recurred with more violence, and the patient was completely exhausted, and evidently could not survive any further loss of blood. The foot was swollen and painful, and it seemed impossible to secure the artery in the sole of the foot, without destroying the organ, and I determined upon tying the femoral artery, which was done without the use of chloroform as the patient lay in his bed, for he was so weak that I feared to disturb him; this secured the bleeding, and the little patient recovered perfectly.

"But notwithstanding the confidence which my experience gives me in the safety of tying the artery at a convenient place on the proximal side of the wound, I would advise, in cases of false aneurism, when there is considerable extravasation of blood, to lay the sack open freely, and tie the vessel at the wound, whenever it can be done without cutting through important parts. The impression is, that a large sac or cavity, containing blood, laid open and exposed to the air, will take on ill-conditioned inflammation. This is generally true, where the extravasation is from contusion, but there is a great dissimilarity in the cases. In the former case, the blood is isolated, and can be scooped out

clean, and the cavity heals kindly; but in the latter case, the blood mingles and clings to the contused parts, and cannot be sundered, and when exposed to the air decomposes and becomes a poison. Another fear that deters from opening the tumour is, that the artery may not be readily found, and the patient suffer from loss of blood. When the artery can be commanded by pressure on the proximal side, there can be no objection, and the bleeding mouth of the wounded vessel is readily discovered. The flesh is pushed away by the pressure of the extravasated blood, and leaves the mouth of the vessel isolated, compared with its position in a fresh open wound. The advantage of this method of operating is, that we get rid of the mass of blood, which will generally have to be discharged sooner or later by a separate opening, when the quantity is large, and we make the operation more certain, for the sac may be fed when the anastomosis is free.—*New Orleans Hospital Gazette*, March, 1855.

Case of Spontaneous Rupture of the Bladder.—Extravasation of Urine.—Operation.—Recovery. Dr. A. V. WILLIAMS, late Physician-in-chief to Ward's Island Hospital, records (*New York Medical Times*, Jan. 1855) the following extremely remarkable case.

A man, aged 32 years, of spare habit, but of great endurance, has for several years laboured under stricture of the urethra, with frequent desire to urinate from irritability of the bladder. He states that on several occasions, he has been unable to pass any water for several hours. On the 9th day of June, 1854, I was called to see him, when he stated that he had not passed any urine for two days; that this morning, when making a violent effort to do so, he felt something give way in his belly, and "felt a snap;" since which he has felt no desire to urinate, but the pain is very great over the belly. I endeavoured to pass a catheter into the bladder, but found it impossible to do so. He was put in a warm bath, a large anodyne administered, and a warm poultice applied over the abdomen.

June 10. He slept some last night, but otherwise remains in the same state, except that the abdomen was not swollen. I could not make any other diagnosis than that some portion of the bladder had given way when he felt the "snap;" and that the effusion of urine into the cavity of the abdomen accounted for the subsidence of the desire to make water, and also caused the other symptoms.

I requested Dr. Willard Parker to meet me, who, on examination, concurred with me as to the nature of the case, and of its desperate character.

On consultation, we agreed that the only chance for the man (and that a very small one), was to open the abdomen above the pubis, cut into the bladder, and pass a catheter, if we could, from within out through the penis, and re-establish a passage in that way. To cut into the bladder from the perineum was useless, as the effusion was above the pelvic fascia; and a puncture through the rectum was impracticable, as the bladder was empty, and could not be felt.

The case was fully stated to the patient, who requested me to "cut away."

After shaving the pubis, I made an incision about four inches long, from the pubis upward in a line with the linea alba, dividing the fibres of the pyramidalis; then very carefully divided the tendon beneath, and with a director dilated it freely. The urine flowed out abundantly from the wound. There was but little hemorrhage. The bladder was deep, and firmly contracted behind the pubis, and so altered in appearance that it could not be recognized as that organ. I pushed up the perineum with one finger, whilst Dr. Parker, with a hook drawing up the bladder, I punctured it with a bistoury; on dilating this opening with the finger, the internal surface was found corrugated and thickened. The opening into the urethra could not be felt, so that the original design of forcing a passage from within outwards, could not be done. Whilst my finger was retained in the bladder, Dr. Parker accordingly passed a grooved sound into the penis, down to the strictured part, and forced it forward until the point was felt by my finger through the thickened coats of the bladder, which were so tough I could not tear it with the nail, but cut upon the end of the sound, with a probe-pointed bistoury, carefully passed along the finger. The wound made in the abdomen was brought together by a single

suture; a catheter introduced through the false passage made into the bladder, a large anodyne given to the patient, and he placed in bed as soon as the operation was completed; he felt greatly relieved, and soon fell asleep.

11th. The patient says he feels pretty comfortable; he only complains of the general soreness of the belly. The urine flows from the wound, and also from the catheter.

12th. Had a bad night; pulse, 130; abdomen tender; urine flows as yesterday; bowels not opened; vomits a green matter; skin hot; but says "he shall get well," which opinion he stuck to throughout. Gave him opium grs. iij, with calomel grs. viij, and directed a pill of calomel gr. ij and opium $\frac{1}{2}$ gr. to be given every two, three, or four hours, according as he is restless; diet accordingly, with poultice to abdomen.

12th. Passed a more comfortable night; the vomiting has ceased; bowels freely purged; pulse, 130; abdomen tender; wound healing above the suture, whilst the urine flows from the lower part above the pubis, and through the catheter; continue the calomel and opium every four hours. The constant dribbling of the urine over the scrotum has produced excoriation, which annoys the patient more than his other troubles. This was relieved by simple cerate, and the parts protected from the urine by an oiled-silk bag.

13th. Patient attacked with violent hiccough, from which he suffers dreadfully. This symptom caused great distress, and continued without intermission for an entire week. Nothing seemed to do any good, and all remedies for it were abandoned, except a pill of opium three or four times a day; the calomel was omitted on account of his gums being sore. The symptoms of peritonitis are subsiding.

21st. The subsidence of the hiccough was a great relief. The patient began to show his sufferings. Beef-tea and milk punch were ordered, and a general supporting regimen was followed throughout the remainder of the treatment, with quinine.

A slough came out of the wound above the pubis, about the size of a pullet's egg, leaving a clean, granulating sore, which healed kindly. On the 27th day after the operation, the wound had entirely closed, and the urine passed through the penis in a fuller stream than it has done for years. The patient entirely recovered, and engaged in his labouring business as a journeyman butcher.

Dr. Cammann's Self-Adjusting Stethoscope.—Dr. Geo. P. CAMMANN, of New York, has invented a self-adjusting stethoscope, which consists of an objective end made of ebony, the extremity of which is about two inches in diameter, two tubes composed of gum elastic and metallic wire, two metallic tubes of German silver, two ivory knobs at the aural extremity, and a movable elastic spring, so arranged as to adjust it, and keep it in its proper position.

M. Landouzy, of Paris, previous to 1850, formed a stethoscope having a number of gum-elastic tubes, by means of which several persons could listen at the same time. Dr. N. B. Marsh, of Cincinnati, in 1851, patented a stethoscope with two gum-elastic tubes, and a membrane over its objective end. Dr. Cammann does not, therefore, claim any originality on account of the two branches of his instrument, but on account of other advantages which it possesses.

The bell-like expansion of the objective extremity has a convoluted excavation, gently curving outwards to present a rounded edge to the chest, in order to prevent causing pain to the patient. The bore of the instrument is two and a half lines in diameter, care being taken to have it made smooth and even. The tubes are made of German silver, with a double curve towards the aural extremities, which curves require to be constructed with great care, so that the ivory knobs may rest closely upon the external openings of the ears. When applied, it is necessary that the orifices of the knobs should point upwards. Some of the instruments are constructed with a spiral, and others with an elastic spring, as shown by the plate. Some of them are so arranged that they can be disjoined, to render them more portable.

One point, heretofore *sub judice*, is settled by this instrument, viz: that the

sound is conducted entirely through the air, and not at all through the media, as these were, for experiment's sake, changed nine or more times, without affecting in the least the intensity of the conducted sound. On making the objective end solid, all sound was lost.

The advantages claimed for the instrument of Dr. Cammann are:—

1. That being applied, it adjusts itself closely to both ears, excluding all external sound.

2. It leaves both hands of the examiner free.

3. It gives sounds pure, and greatly increased in intensity, though differing in quality from those hitherto afforded by auscultation, the pitch being lower. This intensity is produced by both ears being acted upon at once, by the ear-pieces of the instrument fitting closely into the meatus of both ears, and by the smoothness and careful construction of the bore of the stethoscope as to curves, &c., according to the law of reflected sound.

4. Sounds not heard through the instrument in common use can be detected by this.

5. Sounds which are doubtful by ordinary instruments are made perfectly certain. Even when disease is seated in the central part of the lungs, they can be detected, when the ordinary stethoscope will fail to render them recognizable. The same advantages are obtained in examining the morbid sounds of the heart.

The great increase of intensity of sound by this instrument renders it valuable to those with impaired hearing.

In the use of this stethoscope it is necessary that the chest should be uncovered, to prevent all friction between it and the clothes; otherwise the sound thus generated is conducted with such intensity as to embarrass the examiner. A short practice may be required to become familiar with it, in consequence of the increased intensity of the sounds produced by it, and the difference between them and those afforded by ordinary auscultation. Many of the recognized physical signs of thoracic disease will be so modified as to be new to the examiner, but a short experience will enable him to appreciate them, and give them their true value.

These stethoscopes are manufactured and sold by Messrs. George Tieman & Co., No. 63 Chatham street, who pay particular attention to their construction—a point very essential to an instrument of this kind.—*New York Med. Times*, Jan. 1855.

Reduction of Dislocation of the Femur by Manipulation alone.—Dr. THOMAS M. MARKOE, one of the Surgeons of the New York Hospital, has published (*New York Journal of Med.*, Jan. 1855) an account of the cases of dislocation of the femur at the hip-joint, treated by manipulation alone, during the past two years in the hospital to which he is attached, with some very interesting remarks on this method of reduction.

Our readers are aware, that Dr. Wm. W. Reid, of Rochester, N. Y., published in the Transactions of the Medical Society of the State of New York, for 1852, a paper on "dislocation of the femur on the dorsum ili, reducible without pulleys or any other mechanical power," in which it is the object of the writer to show that this displacement can be remedied "by flexing the leg on the thigh, carrying the thigh over the sound one, upward over the pelvis, as high as the umbilicus, and then by abducting and rotating it."

"The fact," Dr. Markoe observes, "that luxations of the hip-joint might be reduced by manipulations, not requiring forcible extension by pulleys or other mechanical contrivance, seems to have presented itself to the mind of several writers both of ancient and of modern times. The idea would appear sometimes to have been suggested by accident, and sometimes to have been the result of reasoning on the mechanism of the joint and its displacements. Such a suggestive accidental reduction occurred in the hands of Dr. Physick, and is related in Dorsey's Surgery. A patient was the subject "of dislocation of the femur directly backwards, and after very powerful efforts had been made to effect the reduction by extension, Prof. Physick, conjecturing that the head might be confined in a slit in the capsular ligament, discontinued the extend-

ing force entirely, and then, with no more force than that of his own hands, abducted the thigh, when the bone instantly slipped into its place."

"A similar occurrence took place in our hospital, about the time of the introduction of the use of chloroform, in a patient with dislocated hip, under the care of Dr. Jno. C. Cheesman. While the preparations for applying mechanical force were being made, Dr. C. made some preliminary movements of the joint, while the patient was fully under the influence of chloroform, and, unexpectedly, the head of the bone slipped into its proper place. Dr. Nathan Smith, Prof. of Surgery in Yale College, succeeded in reducing a luxated femur, by manipulating, with the thigh and leg used as a lever, after the usual plan had failed. It would seem from the report of this case, which, however, is made from memory by his son, Dr. Nathan R. Smith, that it was a deliberate and prearranged plan of procedure, though the considerations which led to its adoption are not mentioned in the record.

"Chelius, in his work on Surgery, gives an outline of the views of four writers, who have proposed to effect the reduction of the dislocated hip by the hands alone of the surgeon and his assistants, and without the aid of pulleys, or, indeed, of any forcible extension. Three of these gentlemen, Wattman, Kluge, and Rust, have described methods not very different from each other, which essentially consist of moderate extension with the hand, combined with movements of rotation of the axis of the limb, adduction, flexion, etc., but with the addition of force applied by a band passed around the upper part of the limb, which is committed to an assistant, and, in the different forms of dislocation, is so applied as to lift the head of the bone from its unnatural resting-place, while the other movements made with the shaft of the limb give an opportunity to the muscles, stretched by the luxation, to draw the head back into the acetabulum. Another surgeon, referred to by Chelius, Colombat, speaks of a method which he has always employed with success, in which the patient stands at a table leaning forward with his chest upon it, and the surgeon, standing behind, bends the knee with one hand, and makes the various movements of the hip-joint, while, with the other hand on the ham, he makes gradual extension by pulling downwards. By this manoeuvre, he states that he dislodges the head of the bone, and without any force accomplishes its reduction. In Casper's *Wochenschrift* for Nov., 1849, there is an account given by Dr. Fischer, of Cologne, of his mode of reducing luxations of the hip, which consists in flexing the femur on the trunk, and then making rotation of the limb, conjoined with adduction, or abduction, as the head of the bone is on one side or the other of the acetabulum. In the *N. Y. Journal of Medicine* for March, 1852, a Dr. Mayr is spoken of as having made use of this procedure of Dr. Fischer, without being aware of Dr. F.'s published statement."

Dr. Reid's observations appear to have been made independently of any knowledge of the previous opinions of others. In his paper he describes the steps by which he was led to the adoption of his mode of operation, and gives five cases of his successful application in practice.

It would thus appear, as remarked by Dr. Markoe, that the barren honour of being the first suggester of the idea of this method does not belong to Dr. Reid, but he accords to him "the higher honour of having caused the idea to assume the shape and value of a fact, and out of the bare suggestion to have, by patient, ingenious, and long-continued investigation and experiment, deduced an available, and, as we think, an exceedingly valuable addition to the resources of Practical Surgery."

Dr. Markoe gives the details of thirteen cases of dislocation of the femur, in all of which, with two exceptions, Dr. Reid's plan was successful.

"With regard to the rationale of the process," Dr. Markoe observes, "most of those who have written on this matter are in the main points agreed. The head of a dislocated femur is retained in its new position by a mechanism which does not exist in any other joint, and which is produced by the fact of the muscles not being inserted into the head, but into the trochanter, nearly three inches from the head, and that from this point of principal muscular insertion the neck goes off at a large angle from the axis of the shaft. From this, it happens that when the head of the femur is thrown out of its socket, the

trochanter no longer stands out more prominent than before, but being held firmly by the muscles which are inserted into its base, it is prevented from rising any more than enough to let the head out of the acetabulum, while the head and neck, slipping to the one side or the other, are found lying in such a manner that the side of the head, neck and trochanter are in contact with some part of the outer surface of the pelvis, varying, of course, in the different forms of luxation. This being borne in mind, it will be clear that any attempt at reduction, which merely brings the head of the bone to the acetabulum, will not succeed in making it enter that cavity, because of the lying-down position of the neck and trochanter against the side of the pelvis. We need, therefore, not only to bring the head over the socket, but at the same time to raise up the trochanter and neck, so as to allow the head to enter. Now, in the ordinary methods of reduction, this raising up of the trochanter, so as to put the neck in the proper direction for the head to enter its socket, is done first, by the action of the pulleys, and the approximation of the head to the socket is done second, by the continuation of the extension. This raising of the trochanter is, of course, opposed strongly by the muscles inserted into its base, causing the head to be pressed more and more firmly against the pelvis, and increasing the friction, and thereby causing, by far, the greater part of the difficulty in bringing down the head to the level of the acetabulum. It is in this, principally, and I am myself disposed to say only, that any active muscular contraction opposes the reduction of a dislocation of the hip-joint. True, the large muscles around the joint are thrown into action as soon as extension is made; but this is an action excited by the extension, and, that it is a very feeble opposing force, is evidenced by the facility with which these muscles give way to the force of a single unaided arm, when a fracture of the neck of the femur is concerned, in which, of course, none of the friction alluded to can occur. This comparative action of the muscles, in fracture and in dislocation, is very strongly and appropriately insisted upon by Dr. Reid.

"The process by manipulation avoids this main difficulty, and, as it were, eludes the opposition of the muscles. The trochanter, being fixed by the insertion into its base of the pyriformis, the two obturators, the gemelli, and the upper part of the quadratus, acts as a fixed point or fulcrum, upon which, by moving the limb, the head of the bone can be made to describe a circle round the fulcrum. When we remember that this fulcrum is not, strictly speaking, a fixed point, but has a certain degree of motion of its own, we can easily see how, by means of this movable fulcrum, the head of the bone can be placed, by varying the motions of the limb, on almost any point within two inches around the acetabulum, and, of course, over the acetabulum itself. If this manipulation is made in such a way as not to raise the trochanter from lying against the pelvis, then, when the head comes over the acetabulum, a slight rotation, such as is given by the rocking motion employed, will sufficiently raise the trochanter to let the head slip in without provoking to opposition the trochanteric muscles, and if the movements be made in such a direction as to relax the stretched muscles, the whole may be accomplished without calling forth the slightest muscular opposition from the beginning to the end of the procedure. This principle, in its application to the different forms of dislocation, presents some variations. In the dislocations on the dorsum, and on the ischiatic notch, for their mechanism is for our purpose identical, the principle has its best illustration; and, if any one will take the skeleton or the dead subject, and go through the process, he will perceive that, by adduction, the tense rotators are relaxed, and that, by flexion of the thigh upon the trunk, the head is caused to pass down behind and below the acetabulum, and then, by carrying the knee out so as to abduct the limb, that the head comes toward the lower portion of the acetabulum where its margin is least prominent. At this point, I wish it to be observed, that our mode of procedure varies a little from Dr. Reid's. He recommends, when the head is brought by abduction close to the lower edge of the acetabulum, that, by the rocking movement already described, it be caused to slip in. This is well, and will probably answer in many cases, but it failed us so completely from the first, that we were led to add the bringing down of the thigh to the straight position in a state of abduc-

tion, still keeping up the rocking motion, and it has been uniformly in the act of thus bringing down the limb, that the reduction has been accomplished. On looking at the parts in the dead subject, it will be seen that this movement of the limb, when the head has reached the lower margin of the acetabulum, tends directly to roll the head upwards over the edge and into the socket. The mechanism of the reduction from the foramen ovale has already been alluded to. I do not know of any case of reduction from the pubes.

"If the proposed plan should prove, on further trial, to be as successful and as free from danger as it thus far has been, one most valuable feature of it, as a surgical resource, will be its availability. Wherever a surgeon, with his bottle of ether, can go, there the dislocated hip can be reduced, without instruments, without appliances, without assistants."

"Everything," Dr. Markoe adds, "in our experience thus far seems to indicate that this method of reducing luxations is as safe, if not safer, so far as the integrity of the joint and its after usefulness is concerned, than the reduction by forcible extension with the pulleys. The method is not, however, without its dangers, and these mainly arise from the immense amount of force which can be exercised by acting on the long arm of so powerful a lever as the whole limb, while the short arm has at most a length of three inches. By the inconsiderate or misdirected action of this lever force, one of three accidents might be produced: either the muscles holding the trochanter, and thereby forming the fulcrum on which the power is applied, might be torn from their attachments; or, if they held fast, the tissues, round and among which the head passes in its movements, may be extensively lacerated or contused; or, lastly, it seems to me very possible that the neck of the bone might be broken by too violent abduction, forcing it against the side of the pelvis. Though happily these dangers are thus far only theoretical, yet the anatomy of the part shows that they are real, and each one of them might have most serious consequences. It would not be possible to lay down any specific rules whereby these dangers are to be avoided, except by insisting on that almost universal law of surgical manipulation, that everything is to be done with gentle moderate force, and never with sudden violence. As far as my recollection serves me, and I myself assisted in almost every case reported, we never have accomplished anything by proceeding in a direction where great force was required to continue the movement, but have always succeeded by finding a direction in which the mere continuance of the movement, without force, has brought the head into the proper position. It will be noticed, by looking over the cases, that in many of them, before the head went into its socket, it slipped about on the outer surface of the pelvis, taking sometimes one and sometimes another of the four positions usually spoken of as the four forms of luxation of the hip. This in some instances happened several times, and in the two instances of failure, this change of position was all that could be accomplished. Now, it cannot be doubted that this extensive movement of the head of the bone must be attended with a corresponding amount of laceration and displacement of the tissues among which it passes, and although the mischief thus done may be confined to the areolar tissue in the muscular interspaces, still it is an injury which may add to the dangers of after-inflammation, and is, if possible, to be avoided. I suppose this can only be done by defining more accurately the precise method of procedure to be adopted in each case, so that no experimental or ineffectual trials shall have to be made, but the operator shall be able at once to do exactly what is necessary to bring the head of the bone to the point desired."

The following case, given at the conclusion of Dr. M.'s paper, has such important bearing upon some of Dr. M.'s remarks that we quote it:—

"Patrick Barry, aged 42, was admitted to the New York Hospital, Oct. 23, 1854, with a dislocation of the left femur, which had occurred seven weeks previously, by a fall from a rail-car while it was in motion. The symptoms were unequivocal, the limb being shortened $1\frac{1}{2}$ inches, the ball of the great toe resting on the instep of the sound foot, and the head of the bone being distinctly felt upon the dorsum of the ilium. The patient was a man of good muscular development, but the injured limb was somewhat wasted and flabby from inaction. Two days after admission he was put under the influence of

ether, and Reid's manipulation was tried. The head descended as usual, until it came opposite to the lower margin of the acetabulum, but from that point, as the limb was brought down, it slipped on to the foramen ovale. The manipulation was repeated several times, with all care, varying the degree of abduction on the various trials, but without success. It was impossible to make the head rise over the lower border of the acetabulum so as to slip into its place. After numerous thorough and careful trials, the manipulation was abandoned and the pulleys ordered to be applied. Before this was done, it was thought best to place the head of the bone on the foramen ovale, and from that point to try and reduce it by the usual method recommended by Sir Astley Cooper. The head was accordingly placed on the foramen, and while the upper part of the thigh was grasped by an assistant and lifted strongly upwards, I took hold of the ankle and made extension and adduction. The head seemed not to move at all under this force, and while making strong adduction a crack was heard, everything became loose about the joint, and on examination it was evident that a fracture of the cervix had taken place, leaving the head in the foramen ovale. There was nothing further to be done but to put the limb up in the straight apparatus, hoping that, if we could obtain union, he would have as useful a limb as those ordinarily left by fracture of the cervix, and certainly a better limb than if the dislocation had been untouched. Thus far, Nov. 25, everything has gone well, and promises union, with a shortening of about an inch. I am sorry that we must accept this case as one of failure of the new plan after what we considered a fair trial; for myself, however, I do most profoundly believe that it failed simply because we have not yet learned enough about the manipulation to adapt it to the condition of parts concerned in this particular instance. That we shall yet acquire that knowledge, I see no reasonable ground to doubt. With regard to the fracture of the cervix, we were all surprised at the slight amount of force which was competent to produce such a mortifying accident. It adds double force to the caution given above, when speaking of the possibility of that accident, and it is not a little remarkable that the paragraph containing that caution was written on the very morning of the day when the production of the fracture verified the necessity of the warning. Dr. Watson, in a note to me, speaks of a fact which, he says, 'I have on undoubted authority, viz: from one of the professors in the School of Medicine in Toronto, Can., that an accident, similar to that of Patrick Barry, occurred in that city, while the surgeon was attempting to reduce a luxation of the hip by Reid's method.' Finally, it must be observed that the new plan is entitled to none of the blame of the fractured cervix. The accident took place after Reid's manipulation was abandoned, and while we were attempting the reduction according to the old established and classical method."

Excision of the Head of the Femur, and Removal of the Upper Rim of the Acetabulum, for Morbus Coxarius.—Dr. LEWIS A. SAYRE records (*New York Journ. Med.*, Jan., 1855) an interesting case of this. The subject of it was a girl, nine years of age, who had been suffering for 18 months with the disease, and which resisted the usual treatment. When seen by Dr. S., an abscess had formed, involving the whole upper front and inner portion of the thigh, accompanied with chills, profuse sweats, and great prostration. The abscess had pointed in two places, and was apparently just ready to open.

"The leg was shortened 2½ inches, and turned inward, but not permanently fixed in its position (as is usual), but allowing of considerable motion, which gave a distinct bony crepitus between the femur and ileum. The pelvis was twisted and drawn upwards. Her general health had become much affected, having lost her appetite, and she was suffering from hectic, with constant chills and profuse sweats, and was only rendered comfortable by the constant use of anodynes."

Dr. S. advised a free opening of the abscess, and, if necessary, the removal of the head of the femur. This was at first objected to by the father, but subsequently consented to, and the operation was performed on the 29th March, 1854.

Dr. S. first laid open the abscess by a free incision of about six inches, over the trochanter major, on the outer aspect of the thigh, and in a line with the femur, and then cut into the floor of the abscess (which principally occupied the inner and front portion of the thigh), and discharged about a pint of thin serous and flaky pus. The finger was then readily passed around the neck of the femur, and detected an opening in the capsular ligament on the inner surface of the neck. The upper border of the acetabulum had been absorbed, and the head of the femur was upon the dorsum of the ileum, near the anterior superior spinous process, surrounded by its capsule (which seemed to have been slipped up), and a large deposit of bone, apparently being an attempt of Nature to make a new acetabulum. But this cavity thus formed had no lining membrane, as the femur grated roughly upon it. Dr. S. then opened the capsular ligament on a line with the external incision, and disarticulated by bringing the leg strongly across the opposite thigh, and then, with a large pair of Luer's forceps, readily cut off the head of the femur, at the lower extremity of the neck. The bone at this point appeared perfectly healthy. Dr. S. was very cautious not to injure the insertion of the *psaos magnus*, or *iliacus internus*, or any of the rotator muscles, which are inserted just behind the trochanter major.

The upper rim of the acetabulum had been absorbed (according to the theory of Dr. March, of Albany), and the new deposit of bone, which was intended to supply its place, was denuded and carious. Dr. S. gouged it off with a sharp, firm chisel, made for that purpose, and, in this way, took off a number of flakes of bone, until he came to a healthy, bleeding surface.

The anterior superior spinous process on its outer surface, and the external lip of the crest of the ileum, was black and carious for some distance, and with the forceps he easily clipped it off until he came to healthy bone. Very little blood was lost in the operation, and after cleaning away all the debris, he brought the leg in the straight position, filled the wound with lint, and dressed with a roller and cold water compress. She was then put to bed, and a cup of strong coffee administered, after which she soon fell asleep.

The child was under the influence of chloroform during the operation, which occupied nearly 20 minutes, and was perfectly insensible the whole time.

The case went on favourably, and, on the fifth of April, Dr. S. applied the straight splint, for counter extension, to the well side, and made extension by means of the foot-board, bringing the limb down to the same length of the opposite. Though some unfavourable symptoms subsequently presented themselves, the cure progressed. After the 1st of August, at each dressing, the body was brought to a right angle with the thighs, to prevent ankylosis.

On the 1st September, when the bandage was removed, there seemed no tendency to retraction of the limb. The splint was reapplied, but the body was left free from the bandage, so as to allow of flexion, in order to prevent ankylosis. By the middle of October, began to walk on crutches, and on the 20th November, Dr. S. reports:

"To-day I placed her in the horizontal position, and measured her carefully, and find there is $\frac{3}{4}$, or nearly $\frac{1}{2}$ of an inch shortening. By taking hold of the foot, the whole body can be drawn down in bed without pain in the joint, and a pressure may be made sufficiently strong to move the pelvis and body upward without producing any shortening of the limb. When she lies upon the back, with the leg extended upon the thigh, she can elevate the heel sixteen inches from the bed, and flex the knee so as to bring the thigh at a right angle with the pelvis; she can rotate it internally so as to touch the other foot, and externally so as to touch the bed. Her general health is perfect, and the case has terminated perfectly successfully."

Dr. S. gives a table of thirty cases, in which excision of the head of the femur has been performed for morbus coxarius; of these, 20 recovered, and 10 died. Of the former, 13 were completely successful; 3 died of an intercurrent disease, at periods varying from three months to two years after the operation; 1 is reported as not having progressed favourably; the remainder were too mangled reported, or too recently performed to decide correctly of results.

Of the latter, 4 died within one week after operation; 1 on the 12th day; 2

in two months; 1 in four and a half months; 1 in some months after; 1 unsuccessful.

Perineal Section for Stricture of the Urethra.—The *New York Journ. of Med.* for March, 1855, contains an interesting article by Dr. FRED. D. LENTE, on this operation, which our readers are aware has been latterly revived by Mr. Syme, of Edinburgh, and its propriety has given rise to much angry discussion in Great Britain. Mr. Syme never performs the operation without first introducing a guide into the bladder, which he insists can always be done, there being, he maintains, no such thing as an *impermeable* stricture. Mr. Fergusson has lately performed this operation in several cases in King's College Hospital, and in his clinical lecture on the occasion, asks whether the operation can be performed in cases in which no instrument can pass. Mr. Lente expresses his surprise at this query, and states that the perineal section, both with and without a guide passed through the stricture, has been by no means an uncommon operation in New York city, for years past, and refers to a table embracing twenty-seven cases of this operation, published by him in the 4th Vol. of the *Transactions of the American Medical Association*.

"The operation of external division without a guide is looked upon," Dr. L. states, "in the New York Hospital, as so practicable and so successful, though certainly, at times, one of the most annoying and difficult of operations, that, in the cases of obstinate retention of urine admitted into the institution during our connection with it, where the introduction of any instrument was found to be absolutely impracticable, the practice of puncturing the bladder was never once resorted to, but relief was always attempted by the perineal incision. In the London hospitals, on the contrary, it would seem that the operation of puncture is generally preferred. Mr. Hilton, Surgeon to Guy's Hospital, says that twenty or thirty such cases have occurred there during the past few years, and reports three cases himself in one number of the *Lancet*; in one of which, the catheter having slipped from the opening (into the rectum), the operation was necessarily repeated *de novo* on the succeeding day; all of these three operations were successful. The operative procedure, in cases where the obstruction is impassable, is briefly this: The patient having been secured in the usual position, a medium-sized catheter or sound is passed down to the stricture and kept in position by an assistant; the incision is then carried down in the median line to the end of the instrument, which is thus exposed; it is then continued downwards towards the posterior end of the stricture (which is usually of some length), and the anterior point of that part of the membranous portion, still unobstructed, and generally *distended* with urine, diligently sought for. This constitutes the only difficult part of the operation, and may occupy from five minutes to an hour or more; generally, from five to fifteen minutes, however, have sufficed to discover it. As soon as a fluctuating point is perceived, either by the touch or by an experimental incision in the proper direction, an opening is made with a sharp-pointed bistoury, a director introduced, and then the end of the instrument, previously introduced through the distal portion of the urethra. It has been the usual custom to retain a *silver* instrument in the canal, secured by an appropriate bandage, as being the most cleanly. This is removed from time to time, and cleaned. In some cases, when the knife or director has been inadvertently removed from the posterior part of the divided urethra, after all the urine has been evacuated, and before the catheter has been passed into the bladder, it has been extremely difficult to find the opening again, and thus to complete the last step of the operation; especially in cases where the anatomical relations of the parts have been disturbed by the existence of abscesses and fistulous canals.

"Regarding the question, so much mooted on the other side of the Atlantic, as to the possibility of passing an instrument in *every* case of stricture, we have only to say for ourselves, on this side, that, in many cases, our best surgeons, after the most persevering and gentle trials with all kinds of instruments, are sometimes completely foiled, and these are the cases to which the operation under discussion has been applied. Most, if not all of the cases contained in the Table were of this character, and all of those which are mentioned as hav-

ing occurred in private practice, with, perhaps, one exception, this having been complicated by large abscesses, and by fistulas. We are convinced of the fact which Mr. Fergusson says he has long had the idea of—"that the seeming dexterity (in passing instruments in these impermeable strictures) was nothing but actual violence;" and that surgeons "appear to pass the instrument easily into the bladder, whilst they are *really forcing* their way through a canal, the relative anatomy of which is very familiar to them." We may, in this connection, remark that, in the practice of the New York Hospital, when even the smallest-sized conical instrument can be introduced, the idea of dividing the perineum, as a means of cure, is not entertained, but a cure by gradual dilatation, with graduated instruments, is confidently expected; we remember no instance of a different result. This being the case, the first step in the operation, as performed by the great Scotch surgeon and by the surgeons of the London hospitals generally, is an argument against the propriety or necessity of any cutting operation whatever; for, why should a patient be subjected to so severe a procedure as the perineal section, when the passage of the guide through the stricture may be followed by larger instruments, and the canal thus enlarged to its normal dimensions? In cases complicated by abscess or by extensive fistulas, it may be, and is often, necessary to perform the cutting operation, even though a small instrument can be introduced. In a case which we have recently had under treatment, and which we may be permitted to introduce here as an exemplification, it was only after repeated trials, even with the important aid of an anæsthetic, and with considerable difficulty, that we could introduce an instrument, and then only one of the fine-pointed, flexible bougies manufactured by the French, and so admirably adapted to these cases, its diameter, at its largest part, being only one-half that of silver catheter No. 1, and yet, in the course of three or four weeks, by careful and gradual dilatation, the urethra was enlarged to the size of No. 10."

Of the twenty-seven cases contained in Dr. Lente's table, three died, two were much relieved, four were relieved, and eighteen were cured. "In some of the cases which were discharged as relieved, a further operation might have resulted in cure, but the patients were unwilling to submit to it," being contented with the alleviation of their sufferings already afforded. In many instances in which the operation was performed, it was under very unfavourable circumstances. In seventeen cases, in which the duration of the existence of the stricture, previous to the operation, is mentioned, the average is seven years. "In most, if not all of the cases, the operation was regarded as the only means of effecting a cure, all other means having failed; and, in many instances, it was necessary, not only for the purpose of rendering the patient's life more comfortable, but for saving it. The proportion of cutting operations for stricture, to the number treated by dilatation, is very small in the New York Hospital."

"We look upon it as a matter of the greatest importance, to establish the feasibility and comparative safety of the perineal section, and especially as performed without a guide, for in most, if not all cases requiring the operation, surgeons find it impracticable to introduce any guide, although one of small size may, perhaps, usually be forced through by one well acquainted with the course of the canal and its relations, but in no case, we think, without danger of making false passages, and thus materially increasing the danger, and diminishing the chances of a perfect cure from the subsequent operation. The cases included in our Table, and those performed in private practice in the city, with like results, will, in our opinion, go far towards increasing the confidence of surgeons in this operation."

Ovariectomy.—This operation was recently performed by Dr. A. MERCIER, of New Orleans. The patient was a woman, 28 years of age, the mother of four children. A swelling was first observed in her right iliac region, about a year before. Six months afterwards she was tapped, and six gallons of a white, thick albuminous fluid drawn off. The effusion rapidly accumulated again, and she was tapped six times subsequently. The operation was performed on the 17th Dec. 1854. The patient having been put under the influence of chlo-

roform, "an incision, nine inches in length, was made over the tumour, extending from the lower ribs to the external edge of the rectus abdominalis. Two small muscular arteries were tied during the course of the incision, and but little blood was lost, either then or subsequently. With some difficulty the adhesions which bound the tumour to the abdominal parietes, the liver, the iliac fossa, and to the omentum, were torn apart with the hand, the intestines, &c. being freely handled for this purpose. Near the pedicle of the tumour the adhesions were so strong, for more than an inch in extent, that the bistoury had to be resorted to. The tumour presented the appearance externally of an enlarged ovary, and such was its size that, in order to draw it out of the abdominal cavity, several deep incisions had first to be made into it, and a large portion of its fluid contents to be evacuated. Strong, thick twine was then tied as forcibly as possible around the pedicle of the tumour, and it was excised about half an inch above the ligature. The internal parts were freely sponged, and the lips of the wound brought together with five sutures, which included all the parts incised—the peritoneum, muscles and integument. The lips of the wound were further approximated with adhesive straps, and covered simply with lint. Openings were left, sufficiently large to admit a ready egress to any fluid contents of the abdomen.

"The tumour, when extracted, measured nine inches in length, and six in diameter. Its weight could not have been less than six pounds. It was of a fibro-cartilaginous character, and composed of a mass of small conglomerated cysts of various sizes, containing a fluid of the colour and consistency of glycerin.

"By the seventh day, the muscular portions of the wound had united, except opposite to the sutures. On the thirteenth day, the ligature came away, and indicated by its appearance that, with a little force, it might have been removed without danger several days before. From this period the flow of serum through the wound, which at first had been considerable, has rapidly decreased."

At the date of the last report, seventeen days after the operation, the wound had almost entirely healed, and the patient was sitting up.—*New Orleans Med. and Surg. Journ.*, Jan. 1855.

The entire Scrotum and Perineum, with one Testicle and its Cord attached, and nearly all the Integuments of the Penis torn off.—Dr. ROBERT W. GIBBES, of Columbia, S. C., relates (*Charleston Medical Journal*, March, 1855) a very interesting case of this. The subject was a coloured man, 22 years of age, who was caught by the shafting in a foundry, and the following sustained: "The entire scrotum was torn off, with the skin and cellular tissue, from two and a half inches above the spine of the pubis down to the edge of the sphincter, and including all the breadth of the perineum, together with the left testicle with five inches of its cord attached, and all the integument and cellular covering of the penis, except a rim nearly half an inch wide at the extremity, and continuous with the mucous membrane of the prepuce.

When seen by Dr. G. the patient was suffering most acutely. Chloroform was immediately administered, and on examination the right testicle was seen hanging down by its bare cord, and apparently covered only by the tunica vaginalis communis as high as the abdominal ring, where the elastic feel of the intestines was distinctly perceptible, as well as on the opposite side, where the end of the cord was so retracted as to render its ligation impossible. Not more than half oz. blood could have been lost, as scarcely any oozing was observed, and the parts separated were almost as clean as if they had been sponged. The gap in the perineum was brought together by three points of the interrupted suture, and, as it was impossible to form a covering for the raw surface and remaining testicle, a simple lint dressing was applied, the penis supported on the left thigh, and the testicle on a small bran cushion placed between the legs.

The patient recovered, and his sexual appetite, he says, is as great as before the accident, and coition as agreeable as ever; the only difference, he observes, is that the semen "does not come as free." One of his fellow-workmen said

to me, "Oh, he is as good a man as ever;" to which Henry replied *that he believed he was.*

Treatment of Ulcers by Anaplasty.—Having in our preceding No. (pp. 276-78) noticed the rival claims of Dr. F. H. HAMILTON and Dr. JOHN WATSON, to a method of treatment of ulcers by Anaplasty, it is but justice to the former surgeon to state that in a subsequent reclamation (*New York Journ. Med.*, Jan. 1855) he denies that Dr. Watson has not anticipated him in either the proposal or the results; but states that Dr. Watson has misapprehended the principle of his operation. This operation consists in transplanting a piece of new and perfectly healthy skin upon the centre of the ulcer, by which means he hopes not only to supply an amount of skin equal to the size of the piece transferred, but to furnish, also, a nucleus from which additional skin shall be formed—to establish a new centre of life—an oasis, from whose outer verge a true and healthy vegetation shall advance in every direction over the exhausted soil.

"It is not improbable," he remarks, "also, that the graft will itself expand, or be drawn centrifugally by the contraction of the surrounding granulations and cicatrix, conversely, as the skin about the ulcer had before been stretched and drawn centripetally, by a similar action of the granulations and cicatrix situated within its free margin, so that, after a time, it will cover more space, independent of any actual growth, than it did originally. The opposite of this happens usually in anaplasty, and would occur here, did the flap equal or exceed in size the wants of the parts to be supplied. The flap would contract, thicken, and project itself above the surface. But in old ulcers, it will generally be found impossible to furnish a direct supply of integument equal to the loss. A deficiency must probably still exist, and sufficient, it is believed, to determine in the transplanted skin a necessity of expansion."

He further states that his proposal dates from the year 1844.

Fungus Hematodes of the Eye; Extirpation; Recovery.—Dr. JAMES BOLTON relates (*Stethoscope*, Feb. and March, 1854) a case which he considers to be an example of fungus hematodes of the eye, occurring in a negro, 35 years of age. The disease was not traceable to any injury; its progress was slow, and for a long time painless. The system had begun to sympathize deeply, exhibiting a cachectic condition. The eyeball was very much protruded. Dr. Bolton extirpated the whole globe. A section of it afterwards showed a fungous tumour of a brownish colour occupying almost the whole interior of the ball, appearing to spring from the ciliary body, and including the iris and choroid coat. The lens and vitreous humour had disappeared; a small quantity of fluid, containing reddish granular particles, was evacuated; the optic nerve was sound. The patient continued well twenty months after the operation.

Results of Twenty-four Operations for Lithotomy.—In the No. of this Journal for July, 1850, Dr. P. C. SPENCER, of Petersburg, Va., reported the results of fifteen operations for lithotomy, and in the *Virginia Medical and Surgical Journal*, for February last, he reports nine more cases. Of these nine, 6 were whites, 5 boys, and 1 man 64 years of age; three were blacks, 2 boys, and 1 man aged 61.

Of the twenty-four cases, Dr. S. lost but two, a proportion of 1 in 12.

Choleraic Epidemic at the Massachusetts State Prison in July, 1854.—Dr. WM. B. MORRIS, Physician to the Massachusetts State Prison, gives (*Boston Medical and Surgical Journal*, March 15, 1855) the following account of the outbreak of cholera in that institution in July last:—

"At midnight, July 27, I was called to attend Peter York, a coloured convict, who had been in solitary confinement for nearly seven years. On arriving at the prison, I found him with a feeble pulse, cool skin, cramps of the abdomen and extremities, purging and vomiting. Thinking it an ordinary case of cholera morbus, I prescribed the usual remedies, and as soon as relief was afforded, returned home. I had scarcely gotten into bed when I was again called; and before reaching the prison a second time, four new cases had occurred

in different parts of the institution. The attacks became from this time so frequent that I was obliged to remain constantly in the hospital, which soon became crowded with patients. During the whole of the 28th, the succeeding night and following day, new cases continued to occur, so that in forty-eight hours from the commencement of the epidemic 205 convicts had been more or less severely attacked. The symptoms varied in intensity in different cases, but in all were characterized, to a greater or less degree, by lividity of the lips and surface of the body, cold extremities, painful cramps, vomiting and purging. In a few instances, also, there was suppression of urine.

"The causes of this sudden outbreak are, to my mind, wholly conjectural. The report that it depended upon diseased beef is entirely without foundation. *No beef had been given at all.* The ration on the 27th, consisted of 'dun-fish' (Mr. Mason and myself examined the lot from which they were taken, and found them to be of the best quality), rice and bread. On the next day there was an entire change of food. I have forgotten now what the diet for that day was, though I have it somewhere among my papers. Yet notwithstanding this change, 86 new cases occurred. There was a very sudden change of temperature on the evening of the 27th, from excessively hot to uncomfortably cool weather. I suffered so much in going to the prison to visit York, that I borrowed an overcoat to wear home. This change of temperature, together with the fact that cholera was prevailing at the time, has always inclined me to believe that atmospheric causes played an important part in the production of this sickness."

Employment of Injections into the Bronchial Tubes, and into Tubercular Cavities of the Lungs.—Dr. HORACE GREEN, of New York, claims (*American Medical Monthly*, Jan. 1855) to have treated with advantage bronchial affections and tuberculosis, "by the direct introduction into the lungs of a strong solution of nitrate of silver injected through" an "elastic tube." The subject was brought before the New York Academy of Medicine on the 6th of December last, and referred to a committee to inquire into and investigate the proposed treatment (*New York Med. Times*, Jan. 1855). Although nearly four months have now elapsed, this committee have not yet made a report. It will be time enough when the projector shall have satisfied the committee of the practicability of his procedure, and of its utility, if practicable, to give it further notice.

Vesico-Vaginal Fistula cured by Sims's Operation.—Dr. A. V. WILLIAMS records (*New York Med. Times*, March, 1855) a case of vesico-vaginal fistula, the opening large enough to admit two fingers, cured by Dr. Sims's operation.

AMERICAN MEDICAL ASSOCIATION.

The eighth annual meeting of the American Medical Association will be held in the city of *Philadelphia* on Tuesday, May 1, 1855.

The secretaries of all societies, and other bodies entitled to representation in the Association, are requested to forward to FRANCIS WEST, M. D., 352 Chestnut St., Philadelphia, one of the secretaries, correct lists of their respective delegations *as soon as they may be appointed*; and it is *earnestly* desired by the Committee of Arrangements that the appointments be made at as early a period as possible.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

The annual session of the Society will be held in Hollidaysburg, on the last Wednesday (30th) of May, at 10 o'clock in the forenoon.

The secretaries of the several County Societies will please forward the lists of delegates to either of the Secretaries, D. FRANCIS CONDE, Philadelphia, or HENRY CARPENTER, Lancaster.